TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Emergency Rule
LSA Document #12-516(E)

DIGEST

Temporarily amends 405 IAC 1-12-1 concerning policy and scope. Temporarily amends 405 IAC 1-12-2 revising definitions for desk audit, like levels of care, nonrebasing year, and rebasing year and adds a definition for CRMNF. Temporarily amends 405 IAC 1-12-4 revising certification requirement in the annual financial report by the provider. Temporarily amends 405 IAC 1-12-21 revising the rates for a CRMNF. Temporarily amends 405 IAC 1-12-24 revising the assessment methodology used in determining the total annual revenue for CRF/DD and ICF/MR facilities. Temporarily amends 405 IAC 1-12-25 to include ICF/MR facilities in reimbursement for day services. Effective August 30, 2012.

SECTION 1. **(a) This SECTION supersedes 405 IAC 1-12-1(a).**

(b) This rule sets forth procedures for payment for services rendered to Medicaid recipients by duly certified nonstate-operated intermediate care facilities for the mentally retarded (ICF/MR), nonstate-operated ICFs/MR licensed as comprehensive rehabilitative management needs facilities (CRMNF), and nonstate-operated community residential facilities for the developmentally disabled (CRF/DD). Reimbursement for facilities operated by the state is governed by 405 IAC 1-17. All payments referred to within this rule for the provider groups and levels of care are contingent upon the following:
(1) Proper and current certification.
(2) Compliance with applicable state and federal statutes and regulations.

SECTION 2. **(a) This SECTION is supplemental to 405 IAC 1-12-2.**

(b) "CRMNF" means a comprehensive rehabilitative management needs facility as defined in LSA Document #12-515(ER) *[LSA Document #12-515(E)]***, SECTION 1.**

SECTION 3. **(a) This SECTION supersedes 405 IAC 1-12-2(n).**

(b) "Desk review" means a review and application of these regulations to a provider submitted financial report including accompanying notes and supplemental information.

SECTION 4. **(a) This SECTION supersedes 405 IAC 1-12-2(v).**

(b) "Like levels of care" means care:
(1) within the same level of licensure provided in a CRF/DD;
(2) provided in a nonstate-operated ICF/MR; or
(3) provided in a nonstate-operated ICF/MR licensed as a CRMNF.

SECTION 5. **(a) This SECTION supersedes 405 IAC 1-12-2(w).**

(b) "Nonrebasing year" means the year during which nonstate operated ICFs/MR and CRFs/DD annual Medicaid rate is not established based on a review of their annual financial report covering their most recently completed historical period. The annual Medicaid rate effective during a nonrebasing year shall be determined by adjusting the Medicaid rate from the previous year by an inflation adjustment. The following years shall be nonrebasing years:
(1) October 1, 2011, through September 30, 2012.
(2) October 1, 2013, through September 30, 2014.
(3) October 1, 2015, through September 30, 2016.
(4) October 1, 2017, through September 30, 2018.
(5) And every second year thereafter.

SECTION 6. **(a) This SECTION supersedes 405 IAC 1-12-2(cc).**

(b) "Rebasing year" means the year during which nonstate operated ICFs/MR and CRFs/DD Medicaid rate is based on a review of their annual financial report covering their most recently completed historical period. The following years shall be rebasing years:

(1) October 1, 2012, through September 30, 2013.
(2) October 1, 2014, through September 30, 2015.
(3) October 1, 2016, through September 30, 2017.
(4) October 1, 2018, through September 30, 2019.
(5) And every second year thereafter.

SECTION 7. **(a) This SECTION supersedes 405 IAC 1-12-4(b).**

(b) The provider's annual financial report shall be submitted using forms prescribed by the office. All data elements and required attachments shall be completed so as to provide full financial disclosure and shall include the following as a minimum:
(1) Patient or resident census data.
(2) Statistical data.
(3) Ownership and related party information.
(4) Statement of all expenses and all income.
(5) Detail of fixed assets and patient or resident related interest bearing debt.
(6) Complete balance sheet data.
(7) Schedule of Medicaid and private pay charges in effect on the last day of the reporting period and on the rate effective date as defined by this rule. Private pay charges shall be the lowest usual and ordinary charge.
(8) Certification statement signed by the provider that:
(A) the data are true, accurate, related to patient or resident care; an *[sic]*
(B) the expenses not related to patient or resident care have been clearly identified.
(9) Certification statement signed by the preparer, if different from the provider, that the data were compiled from all information provided to the preparer by the provider, and as such are true and accurate to the best of the preparer's knowledge.

SECTION 8. **(a) This SECTION supersedes 405 IAC 1-12-21(d).**

(b) Any ICFs/MR that is licensed as a CRMNF will be paid at a rate of six hundred thirty-nine dollars and eighteen cents ($639.18) per resident day. This per diem rate is available only upon certification as a Medicaid ICF/MR and licensure by the division of disability and rehabilitative services. ICFs/MR that are licensed as CRMNFs will not receive a base rate nor be subject to the base rate reporting requirements at 405 IAC 1-12-5.

SECTION 9. **(a) This SECTION supersedes 405 IAC 1-12-24.**

(b) CRF/DD and ICF/MR facilities that are not operated by the state will be assessed an amount that is based on total annual facility revenue. In determining total annual revenue when the financial report period is other than three hundred sixty-five (365) days, the total revenue shall be annualized based on the number of days in the reporting period. The assessment percentage applied to total annual revenue shall be six percent (6%). In no event shall the assessment percentage exceed the percentage determined to be eligible for federal financial participation under federal law.

(c) The assessment on provider total annual revenue authorized by IC 12-15-32-11 shall be an allowable cost for cost reporting and audit purposes. Total annual revenue is determined as follows:
(1) for an annual rate review, from the provider's previous annual financial reporting period as set out in 405 IAC 1-12-4(a);
(2) for a base rate review, from the provider's previous base financial reporting period as set out in 405 IAC 1-12-5(c); or
(3) for an initial interim rate review for a new provider that is not the result of a change of ownership, the fiftieth percentile provider's assessment for a like level of care shall be used as determined in 405 IAC 1-12-5(a). The fiftieth percentile provider's assessment is divided by their resident days to determine the assessment per resident day amount. The assessment per resident day amount is then multiplied by the annualized bed days available to determine the new provider's annualized assessment.
Providers will submit data to calculate the amount of provider assessment with their annual and base rate reviews as set out in 405 IAC 1-12-4(a) and 405 IAC 1-12-5(c) of this rule, using forms or in a format prescribed by the office. These forms are subject to audit by the office or its designee.

(d) If federal financial participation to match the assessment becomes unavailable under federal law

after the implementation date, the authority to impose the assessment terminates on the date that the federal statutory, regulatory, or interpretive change takes place, and such termination will apply prospectively. In addition, prospective termination of the assessment as described in this subsection will result in the simultaneous termination of the assessment being considered as an allowable cost for rate setting purposes.

(e) For an ICFs/MR that is licensed as a CRMNF, the total annual revenue on which the assessment is based shall be determined as follows:

(1) For the initial interim rate review, available bed days times the projected occupancy rate of sixty-nine percent (69%) times the approved Medicaid rate issued to the provider.

(2) For annual rate reviews from the provider's previous annual financial reporting period as set out in 405 IAC 1-12-4(a).

SECTION 10. **(a) This SECTION supersedes 405 IAC 1-12-25.**

(b) For ICF/MR and CRF/DD facilities the all-inclusive per diem rate shall include reimbursement for all day habilitation services. Costs associated with day habilitation services shall be reported to the office on the annual or historical financial report form using forms prescribed by the office. Allowable day habilitation costs shall be included in determining a provider's allowable costs for rate setting purposes in accordance with all sections of this rule.

SECTION 11. SECTIONS 1 through 10 of this document expire June 30, 2013.

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